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A Series of Questions about PC-MH Part II

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Continuing to address the questions submitted to us by a national publication, we considered the question: **"You built your own Electronic Health Record system at SETMA. ' Why did you feel the need to do that?'"**

In October, 1997, SETMA attended the Medical Group Management Association (MGMA) meeting to preview electronic-health-record (EHR) solutions. In March, 1998, SETMA signed a contract with an EHR vendor. We deployed the enterprise practice management (EMP) side of the system in August, 1998 and the EHR on January 26, 1999. By Friday, January 29th, we documented every patient encounter in the EHR. The anxiety producing part of this is that when we bought our EMR, 50% of the companies whose products we looked at five months before were out of business. On March 30, 1998, we had written a check for $650,000, what if that company went out of business.

The thing which drove us to electronic medical records was the certainty that the complex, technologically-based healthcare of the 21st century could not be effectively, successfully and excellently navigated with "pencil and paper" (19th Century medical records technology), or with "dictation and transcription" (20th Century medical records technology). Without the power of electronics, we did not think we could meet the challenges of the 21st century.

However, after only three months of using the EMR (January 22, 1999 to May 1, 1999), we realized that EMR was not a goal worthy of the treasure, time and stress we were expending. In May, 1999, four seminal events transformed SETMA's healthcare vision and delivery. First, we concluded that EHR was too hard and too expensive if all we gained was the ability to document an encounter electronically. EHR was only "worth it," if we leveraged electronics to improve care for each patient; to eliminate errors which were dangerous to the health of our patients; and, if we could develop electronic functionalities for improving the health and the care of our patients. We also recognized that healthcare costs were out of control and that EHR could help decrease that cost while improving care. Therefore, we began designing disease-management and population-health tools, which included "follow-up documents," allowing SETMA providers to summarize patients' healthcare goals with personalized steps of action through which to meet those goals. We transformed our vision from how many x-rays and lab tests were done and how many patients were seen, to measurable standards of excellence of care and to actions for the reducing of the cost of care. We learned that excellence and expensive are not synonyms.

Second, from Peter Senge's *The Fifth Discipline*, we defined the principles which guided our development of an EHR and the steps of our practice transformation from an EMR to

an electronic patient management (EPM); they were to:

1. Pursue Electronic Patient Management rather than Electronic Patient Records
2. Bring to every patient encounter what is known, not what a particular provider knows
3. Make it easier to do "it" right than not to do it at all
4. Continually challenge providers to improve their performance
5. Infuse new knowledge and decision-making tools throughout an organization instantly
6. Promote continuity of care with patient education, information and plans of care
7. Enlist patients as partners and collaborators in their own health improvement
8. Evaluate the care of patients and populations of patients longitudinally
9. Audit provider performance based on endorsed quality measurement sets
10. Integrate electronic tools in an intuitive fashion giving patients the benefit of expert knowledge about specific conditions

In 2009, we would discover that these principles are essentially the principles of patient-centered medical home (PC-MH) and that in the years between 1999 and 2009, we had prepared SETMA to formally become a patient-centered Medical home. Between 2009 and 2014, SETMA would become accredited as a medical home by all of the organizations offering recognition or accreditation for medical home: NCQA, AAAHC, URAC and The Joint Commission.

The third seminal event was the preparation of a philosophical base for our future; developed in May, 1999, this blueprint was published in October, 1999. It was entitled, More Than a Transcription Service: Revolutionizing the Practice of Medicine With Electronic Health Records which Evolves into Electronic Patient Management". As we began defining and developing critical supports required for success in Performance Improvement, we found them to be:

- Care where the same data base is being used at ALL points of care.
- A robust EHR to accomplish the above.
- A robust business-intelligence analytics system, which allows for real-time data analysis at the point of care.
- A laser printer in every examination room so that personalized evaluational, educational and engagement materials can be provided to every patient at every encounter, with the patient's personal health data displayed and analyzed for individual goal setting and decision making.
- Quality metric tracking, auditing and statistical analysis.
- Public Reporting of quality metric performance by provider name.
- Quality Improvement initiatives based on tracking, auditing and analysis of metrics.
- Shared vision among all providers, support staff and administrators - a personal passion for excellence -- which creates its own internalized, sustainable energy for the work of healthcare transformation.
- Celebratory culture which does not compete with others but continually improves the organization's own performance, using others as motivation but not as a standard.
- Monthly peer-review sessions with all providers, to review provider performance and

to provide education in the use of electronic tools.
- Adequate financial support for the infrastructure of transformation.
- Respect of the personal value of others and the caring for people as individuals.
- An active Department of Care Coordination and a hospital-care support team which is in the hospital twenty-four hours a day, seven days a week.
- Aggressive end-of-life counseling with all patients over fifty, and active employment of hospice in the care of patients when appropriate.

Fourth, my co-founding partner lamented that we were not crawling yet with our use of the EMR. I agreed and asked him, "When your son first turned over in bed, did you lament that he could not walk, or did you celebrate this first milestone of muscular coordination of turning over in bed?" He smiled and I said, "We may not be crawling yet, but we have started. If in a year, we are doing only what we are currently doing, I will join your lamentation, but today I am celebrating that we have begun." These four seminal events have defined SETMA's EMR pilgrimage and are the foundation of our success.

To transform our delivery of healthcare required that we design and build our own EMR as no existing EMR shared our vision, philosophy and goals. Now the Federal Office of National Coordinator's Meaningful Use has required us to take steps backwards to do what CMS wants the way they want it done. We have repeatedly addressed with CMS that if they continue to require that everyone do the same thing the same way, they will stifle creativity, transformation and generative thinking. As we worked on our EMR, we exercised all of these and solved difficult problems effectively and quickly. That is why we built our own EMR.

SETMA continues to innovate and to find new and creative ways to solve complex healthcare delivery problems. We continue to meet and exceed Federal and State requirements for security and privacy while designing tools which help our colleagues and patients fulfill their responsibilities in healthcare.